TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
METROCREST SURGERY CENTER

Respondent Name
TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

MFDR Tracking Number
M4-17-1970-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
February 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are disputing the allowed amount of the attached claim. . . . CPT 29827 allows $5797.92 (pays at 100%) = $5797.92."

Amount in Dispute: $901.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the reimbursement coding for this procedure, and determined that Maximum Allowable Reimbursement was properly calculated for this service."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 27, 2016	Ambulatory Surgery Services	$901.61	$901.61

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the medical fee guideline for ambulatory surgery centers.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
   - 983 – CHARGE FOR THIS PROCEDURE EXCEEDS MEDICARE ASC SCHEDULE ALLOWNCE.
   - T124 – LICENSE MUST APPEAR IN BOX 33B OF THE HCFA 1500 FORM.

- 8 – THE SUPPLY CHARGE WAS DISALLOWED AS IT WAS NOT ADEQUATLEY IDENTIFIED. PLEASE RESUBMIT WITH INVOICE.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 1001 – BASED ON THE CORRECTED BILLING AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER, WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.
- 947 – UPHELD. NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED.

Issues

1. What is the recommended reimbursement for the disputed health care?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards facility reimbursement of an ambulatory surgery center subject to 28 Texas Administrative Code §134.402(f), which requires that the calculation used to establish the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 Federal Register, or its successor.

   The following minimal modifications apply:

   (1) Reimbursement for non-device intensive procedures shall be:
      (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or
      (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of:
         (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and
         (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent.

   (2) Reimbursement for device intensive procedures shall be:
      (A) the sum of:
         (i) the ASC device portion; and
         (ii) the ASC service portion multiplied by 235 percent; or
      (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of:
         (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and
         (ii) the ASC service portion multiplied by 235 percent.

   Review of the submitted materials finds no request for separate reimbursement of implantable items.

   The respondent's position statement does not assert that separate reimbursement for implantables was requested. The respondent did not provided documentation to support that separate reimbursement was requested. The respondent asserts that "The Carrier has reviewed the reimbursement coding for this procedure, and determined that Maximum Allowable Reimbursement was properly calculated for this service." However, the insurance carrier reimbursed the implantables separately and paid the non-device intensive primary surgery at the reduced rate of 153%.

   As separate reimbursement for implantable items was not requested, the primary surgery should have been paid at the greater reimbursement rate of 235%, inclusive of implantables.

Reimbursement is calculated as follows:

- Procedure code 29827, September 27, 2016, has status indicator A2 denoting ASC procedures paid per Rule §134.402(f)(1). The Addendum AA rate for this procedure is $2,486.22. This amount is divided in two halves, representing the labor-related and non-labor-related portions of $1,243.11 each. The labor-related half is multiplied by the facility wage index of 0.9847 for a geographically adjusted labor portion of $1,224.09. This is added back to the non-labor half. The sum is the Medicare ASC facility rate of $2,467.20. This amount multiplied by the Division conversion factor of 235% is $5,797.92.
- Procedure code C1713, service date September 27, 2016, represents supply items that per Medicare policy are not separately paid; reimbursement is packaged with the payment for the primary surgery.

2. The total allowable reimbursement for the services in dispute is $5,797.92. The insurance carrier has paid $4,896.31, leaving an amount due to the requestor of $901.61. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $901.61.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $901.61, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	March 24, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.